



UNITED STATES MARINE CORPS  
Commanding General  
Box 788100  
MARINE CORPS AIR GROUND COMBAT CENTER  
TWENTYNINE PALMS, CALIFORNIA 92278-0100

CCO 6400.1D  
127  
26 May 99

COMBAT CENTER ORDER 6400.1D w/Ch 1

From: Commanding General  
To: Distribution List

Subj: PROCEDURES FOR FIRE SERVICE EMERGENCY MEDICAL SERVICES (EMS)

Ref: (a) MCO 11320.23A  
(b) Inland County Emergency Medical Agency (ICEMA) Protocols  
(c) MOU between Fire Department and Naval Hospital (NOTAL)  
(d) ICS 420-1 (NOTAL)

Encl: (1) Incident Command  
(2) Infectious Disease Exposure Prevention  
(3) EMSA Standard Practice Triage  
(4) EMSA Standard Practice Radio Communications  
(5) Ambulance Patient Care Record  
(6) Mutual Aid

1. Purpose. To establish policy for Emergency Medical Services (EMS) and "First Responder" responsibilities per reference (a).

2. Cancellation. CCO 6400.1C.

3. Information. Considering the important benefits of a comprehensive EMS system to Marines, assigned Naval personnel, dependent families, civilian employees, guests, and visitors, this command has established this Order to ensure proper and prompt emergency medical services are available to those who might need it.

4. Action

a. Fire Department

(1) All Fire Department personnel shall be trained and certified as Emergency Medical Technicians (EMT'S). Additionally, personnel shall be certified EMT'S through Inland County Emergency Medical Agency (ICEMA) with current Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) cards per reference (b).

(2) Primary response and transportation of all medical emergencies aboard the Combat Center shall be provided by the Fire Department per reference (c).

(3) Provide emergency transports to another facility, i.e., Hi-Desert, Desert Hospital, etc., in the event that the Naval Hospital cannot receive additional patient(s), i.e., multi-casualty incident.

(4) Initial response assignments shall be one engine/truck company with a Driver/EMT and a Fire Officer/EMT, and one ambulance with two Firefighters/EMT'S, for a total of four personnel.

(5) Personnel assigned to the ambulance as drivers shall have a valid California State drivers license and a current National Academy of Professional Drivers (NAPD) certificate or Emergency Vehicle Operators Certificate (EVOC).

(6) The Incident Commander shall be the senior Fire Officer/ EMT on-scene, and shall activate the EMS system (see enclosure (1)), per reference (d). The Incident Commander shall maintain overall operational control of the scene. In the event of a traffic accident, domestic disturbance, etc., the Provost Marshal Office (PMO) shall be the overall Incident Commander, with the Fire Department remaining the governing authority over patient(s) care and safety.

(7) Fire Department Dispatch shall notify PMO for police assistance and the Naval Hospital to stand-by for field contact.

(8) Extrication, disentanglement, and search and rescue shall be conducted by Fire Department personnel only.

(9) All Fire Department personnel shall wear full protective clothing and self-contained breathing apparatus (SCBA) as dictated by the Incident Commander, i.e., fire, traffic accidents, or other hazardous environments.

(10) Upon arrival at all medical emergencies, the Fire Department shall establish contact with the emergency department physician after patient(s) assessment has been accomplished. Fire Department personnel shall administer treatment of patient(s) as necessary and within the operational protocols of ICEMA (see enclosures (2) and (3) as applicable).

(11) The Fire Department shall provide information to Naval Hospital personnel regarding patient(s) status via radio communications (see enclosure (4)), until turnover of patient(s) is complete at the Naval Hospital.

(12) The Fire Department shall provide the Naval Hospital with an ambulance patient care record, (see enclosure (5)), during turnover of patient(s). It shall be established with proper protocol and continuity of care and shall indicate the necessary treatment given, vital signs taken, and other pertinent information regarding care and treatment of the patient(s).

(13) If the patient(s) refuses treatment, the Medical and Liability Release form, reverse side of enclosure (5), shall be completed in its entirety.

(14) Personnel assigned to the ambulance shall resupply the unit as needed after each medical response from Naval Hospital inventory on a "one-for-one" exchange, prior to placing the unit back in service.

(15) If the ambulance requires disinfecting or decontamination, the unit shall be placed out of service until such procedures have been accomplished. Dispatch shall notify the Naval Hospital immediately of the status and approximate length of down-time so they can assume primary response of a medical unit. Dispatch shall

notify the Naval Hospital immediately when the unit is placed back in service. This procedure shall also apply in the event a unit is dead-lined for mechanical maintenance and/or repairs.

(16) Ambulances shall be maintained in a ready status at all times and per ICEMA protocols for BLS ambulances.

(17) Firefighters/EMT's assigned to the ambulance unit(s) for their 24 hour shift, shall:

(a) Inventory the contents during morning check-out to ensure all medical supplies and equipment required are accounted for, serviceable, and stored in appropriate locations.

(b) Perform radio check-out procedures with Dispatch and Naval Hospital emergency room personnel.

(c) Perform vehicle check-out and maintenance.

(d) Correct and/or report any discrepancies to the engine/truck company officer.

(18) An on-going, comprehensive communication training program shall be developed and maintained to ensure that techniques, procedures, and radio terminologies are current and understood by personnel performing these functions, to include Emergency Medical Dispatch (EMD).

(19) Respond to off-base emergencies upon request only, per Morongo Basin Ambulance (MBA).

b. Naval Hospital

(1) Maintain ambulance response capabilities for primary response in the event that:

(a) The Fire Department has committed resources to a working fire, hazardous materials incident, or other emergency.

(b) Dispatch receives simultaneous or multiple emergency medical calls.

(c) Simultaneous emergency calls of fire and medical.

(2) Maintain ambulance capabilities as required for multi-casualty emergencies, long-term transport, and other non-emergency requirements, parades, ceremonies, recreational activities.

(3) Shall respond as directed by Fire Department Dispatch. Any clarifications regarding response criteria, by either the Hospital or the Fire Department, shall be accomplished AFTER the medical emergency is complete and patient(s) care has been established.

(4) Provide qualified emergency room personnel/physicians to receive and communicate patient(s) status information prior to hospital arrival. If the hospital cannot receive patient(s), this information shall be communicated to Fire

CCO 6400.1D  
26 May 99

Department personnel during patient assessment and field information exchange prior to arrival at the Naval Hospital.

(5) Notify Fire Department Dispatch immediately if ambulance(s) are placed out of service due to mechanical reasons and/or commitments to long-term transports, expected length of time, and when they are placed back in service.

(6) When providing support to the Fire Department, establish contact with the Incident Commander/Triage Officer for assignment.

(7) Response criteria shall be in accordance with reference (c) and all applicable enclosures.

(8) If the hospital is notified of an emergency which must be responded to, immediate contact shall be made with the Fire Department Dispatch.

(9) Resupply expended medical supplies on a "one-for-one" exchange, to include any equipment on the original inventory list provided with initial assignment of the ambulances to the Fire Department.

(10) Continue disposal responsibilities of all Bio-Medical waste accumulated during responses per reference (c).

(11) Participate, as feasible, in cross-training with the Fire Department in all phases of EMS services.

(12) Maintain all preventive maintenance and fuel costs of ambulances assigned to the Fire Department.

c. PMO:

(1) Establish Incident Command per enclosure (1) at the scene of an incident that falls under the cognizance of law enforcement, i.e., traffic accident, domestic disturbance.

(2) Maintain 24 hour liaison with the Fire Department through the Desk Sergeant.

(3) Upon notification from the Fire Department Dispatch, respond and report to the Incident Commander for traffic and/or crowd control, area security, and other duties as requested, until relieved by proper authority.

(4) If an emergency is reported to PMO via any other means other than the Fire Department Dispatch, immediately contact the Fire Department.

d. Base Communication System. The EMS communication system aboard the Combat Center is activated by dialing 9-1-1. All phones aboard the Combat Center have 9-1-1 capabilities, however, pay phones and phones in Family Housing are the only ones which register an address on the console in the Fire Department Dispatch Center. Therefore, the reporting party must supply the Dispatcher with the building number/address and remain on the line until released by the Dispatcher. By dialing 9-1-1 in the event of an emergency, the appropriate emergency response personnel will be dispatched.

e. Organizational and Section Heads. Those involved shall ensure their personnel are familiar with and comply with this Order.

CCO 6400.1D  
26 May 99

5. Summary of Revision. This revision contains major administrative changes and should be read in its entirety.

6. Applicability. This Order is applicable to all commands and organizations located aboard the Combat Center.

//signed//  
D. T. LENNOX  
Chief of Staff

DISTRIBUTION: A-1

INCIDENT COMMAND

1. The Fire Department will be the "First Responder" on all medical emergencies aboard the Combat Center. The senior fire department officer or EMT, upon arrival at the scene, shall assume the duties of Incident Commander/Triage Officer. Fire Department personnel shall provide those persons requiring medical treatment with primary care, life support, stabilization, and/or other services as necessary. Upon arrival of paramedics (if mutual aid is exercised) ICEMA protocols shall be established and followed.
2. Should qualified Naval medical personnel be first "on-scene" and have initiated medical treatment, upon arrival of the Fire Department, the transfer of patient(s) and medical information to Fire Department personnel shall be accomplished. Fire Department personnel shall assume incident command and provide remaining medical treatment or assistance to higher medical authority if present, as required by ICEMA protocols.
3. In the event that PMO is first "on-scene" or arrive at the request of the Fire Department to an incident requiring law enforcement intervention, i.e., traffic accident, domestic disturbance, they shall assume overall Incident Command, with the exception of patient care and safety, relinquishing control to the Senior Fire Officer on scene.
4. In addition to the above, the Incident Commander (I.C.) shall:
  - a. Assess the incident situation.
  - b. Set up the command post and supervise operations.
  - c. Activate elements of the Incident Command System (ICS) per reference (c).
  - d. Coordinate staff activity.
  - e. Request additional resources and/or personnel.
  - f. Approve demobilization.
  - g. Be responsible for the safety of all personnel at the scene.

## INFECTIOUS DISEASE EXPOSURE PREVENTION

1. Due to the location of this facility within San Bernardino County, our EMS procedures are co-governed by the Federal Government and County Protocol. An exposure of a health-care provider to an infectious disease requires very specific conditions. The virus normally is directly introduced into the person's body. In the health-care environment, this means an infected patient's blood or body fluid must be introduced through the skin or by contact with the eyes, mouth, or nose.
2. The most important factor in protecting health-care providers from acquiring an infectious disease is to carefully follow infection control guidelines.
3. Any patient's blood or body fluid must be considered as infected. This means appropriate protective attire such as gloves, masks, and eye protection must be worn when the likelihood of exposure is high. This is important for first responders to situations involving open injuries. Whenever responding to a medical emergency the following protection will be provided and utilized as required:
  - a. Gloves
    - (1) Heavy duty or leather gloves should be worn when performing extrication procedures to protect the hands from cuts and scratches that could become contaminated with a patient's blood or body fluids.
    - (2) Mid-weight rubber gloves (Playtex type) should be worn for those non-patient care duties that may involve handling of equipment and/or evidence items contaminated with blood or secretions as well as cleaning and decontaminating any equipments utilized.
    - (3) Medical grade latex gloves should be worn for all patient care procedures that may involve contamination of the hands with blood or body fluids. These include dressing and splinting open injuries, establishing patient airways, etc.
  - b. Masks. Medical-grade face masks should be worn by direct care providers in those situations where blood and/or body secretions could be splashed into the providers mouth.
  - c. Eye Protection. Should be worn in those situations where blood or body fluids can be splashed into a providers eyes.
4. Since most non-disposable pre-hospital equipment does not interface directly with the patient's cardiovascular system or respiratory

CCO 6400.1D  
26 May 99

system, sterilization and high level disinfection are not required. Decontamination can be accomplished in most cases by thorough cleaning with hot, soapy water. HOWEVER, if the equipment has become contaminated with blood, body fluids, or a known infectious/contagious disease, cleaning can be accomplished by utilizing the below listed solution:

Bleach. 1:10 dilution. One cup bleach to ten cups water. (Slightly more than 1/2 gallon). Contact time ten to thirty minutes for high level decontamination.

5. All equipment used on a medical emergency shall be disposed of in the proper container provided to handle contaminated equipment, i.e., gloves, masks, eye protection, soiled bandages, or other disposable items.

6. After each emergency response where exposure to bloodborne pathogens exists, hands shall be washed as soon as feasible after removal of gloves or other personal protective equipment (PPE). Other PPE shall be likewise decontaminated, disinfected, if contact with blood or body fluids has been made.

7. All infectious control procedures shall be closely monitored by the Incident Commander before, during, and after the medical response.

ENCLOSURE (2)

ICEMA STANDARD PRACTICE TRIAGE  
EMERGENCY MEDICAL SERVICES AUTHORITY  
EMT-I  
STANDARD PRACTICE  
TRIAGE

Effective 9/1/85  
Approved by Board Action 5/10/85

ALL EMT-I'S IN THE ICEMA REGION WILL FOLLOW THE POLICES AND PROCEDURES BELOW IN THE TREATMENT OF TRIAGE.

1. Highest medical authority is in charge of triage.
2. Protect all rescuers and bystanders from environmental hazards.
3. Determine manpower and equipment needs and call for additional assistance as needed.
4. Primary survey on all patients:
  - a. Correct immediate life-threatening conditions.
  - b. Tag patients as to category (immediate or delayed).
  - c. In a major disaster, patients will be gathered into triage areas by category.
5. Available manpower and equipment will be assigned to patients in immediate category. Secondary assessments and treatment of patients that fall into immediate category.
6. Hospital(s) will be notified of number and estimated severity of patients.
7. Transport patients in the immediate category first.
8. Medical authority in charge should remain at scene to direct additional units.
9. Secondary assessment to be done on all remaining patients.
10. Treat and transport as indicated by priority, equipment, and manpower availability.

ENCLOSURE (3)

CCO 6400.1D  
26 May 99

NOTE:

1. Communications with the hospital, other ambulances and rescue vehicles is paramount to the successful management of a triage situation. Tagging patients is helpful in contributing to efficient care.
2. One person must take charge, directing patient treatment, relegating equipment and proper loading positions, i.e. use of primary cot, availability of suction, and remain in charge until relieved by a more qualified individual.
3. Suggested guidelines for prioritization of patients:

SUGGESTED GUIDELINES FOR PRIORITIZATION OF PATIENTS

-----  
Immediate

Airway obstruction  
Respiratory insufficiency  
Cardiac arrest (see below)  
Severe blood loss

Unconsciousness due to trauma  
Head injuries with decreasing  
level of consciousness

Open chest wound

Severe shock  
Burns involving respiratory tract

Cardiac arrest may become Delayed category if sufficient personnel are not available to treat all other Immediate category patients.

Delayed

-----  
Severe burns  
Spinal cord injuries  
Moderate blood loss  
Abdominal evisceration  
Minor fractures  
Soft tissue injuries  
-----

Impending shock  
Head injuries with stable  
level of consciousness  
Major or multiple fractures  
Minor burns

ENCLOSURE (3)

EMERGENCY MEDICAL SERVICES AUTHORITY

EMT-II

MULTI-CASUALTY INCIDENT OPERATIONAL PROCEDURE PROTOCOL

Effective: 5/01/89

**PURPOSE:**

MCI Operational Protocol should be used whenever personnel and equipment are not adequate to care for the number of victims involved at an incident.

1. Establish an operational structure for an MCI.
2. Define roles and duties of responding personnel.
3. Establish standard approach to triage.
4. Facilitate effectiveness of multi-agency response.

This protocol is intended for use only during a multi-casualty incident. The individual county's Disaster Plan will be utilized during a declared disaster.

**DEFINITIONS:**

Multi-Casualty Incident: Multi-casualty incident exists when personnel and equipment are not adequate to care for all the victims involved. A normal level of stabilization and care cannot be achieved until additional resources are available.

Goal: To do the most good for the greatest number of victims.

Method: The incident command system shall be the organizational structure used in the ICEMA Region. The S.T.A.R.T. program is adopted as a standard method of triage.

ENCLOSURE (3)

CCO 6400.1D  
26 May 99

EMT-I  
MULTI-CASUALTY INCIDENT PROCEDURE

EFFECTIVE: 5-1-89

## **OVERVIEW**

### Initial Responders:

1. The first medical unit on scene will report to the Incident Commander or establish the Incident Command System if it is not operational.
2. The first unit on scene shall assess (size up) the scene. This will consist of a quick count of total victims and approximate type and number of injuries. The type and number of additional resources or equipment should also be assessed and requested.
3. The first unit on scene will establish radio communications with the medical communication resource center of the appropriate county. The first unit on scene will inform the communications center of the MCI and an assessment (size-up.) A request shall be made for an inventory of the local/regional emergency department. The number of Immediate and Delayed patients each emergency department is capable of handling will be recorded.
4. Subsequent units arriving on scene will report to the Incident Commander for assignment. The goal of the medical personnel at the scene of a multi-casualty incident is:

Size-up (assess type of incident, location, number of casualties, type of injuries, identify Incident Commander)

Triage victims.

Activate communication systems.

Request additional resources (personnel and equipment, etc.) and orders.

Transport the most immediate injured first, to the most appropriate available facility.

### Command:

1. Overall command is under the direction of the incident commander. The incident commander will designate a medical group supervisor to oversee the medical aspect of the scene.
2. The Incident Commander shall ensure the safety of the scene, rescuer, and bystanders.

ENCLOSURE (3)

EMT-I  
MULTI-CASUALTY INCIDENT PROCEDURE

EFFECTIVE: 5-1-89

3. The incident commander shall ensure that adequate resources are summoned.
4. The incident commander may designate a:
  - a. Triage unit leader.
  - b. Treatment managers assigned to the immediate and delayed treatment areas.
  - c. Medical Transportation Unit Leader to determine the patient destination from the scene to the surrounding facilities.
  - d. Medical Communication Manager.
5. EMT-I units responding should report to the staging area for assignments by the medical supervisor.
6. EMT-I's will function within their scope of practice.
7. Law enforcement will secure the site for rescue operations.
8. Equipment, supplies and personnel will be brought to the staging area. They will be inventoried and dispensed as needed.

Triage:

1. The S.T.A.R.T. method of triage will be used. Personnel will spend no more than 30-60 seconds per patient triaging.
2. Treatment rendered will initially be confined to airway positioning and hemorrhage control.
3. Patients will be designated:
  - a. Black: Dead/Expectant, those who have died or those who have sustained catastrophic life-threatening injuries but have a low probability of survival.
  - b. Red: Immediate, those with life threatening injuries but who also have a high probability of survival.
  - c. Yellow: Delayed, those who have sustained serious injuries but can wait for treatment.
  - d. Green: Minor, ambulatory or walking wounded, minimum or no medical aid.

ENCLOSURE (3)

CCO 6400.1D  
26 May 99

4. Patients will be triaged:
  - a. At the site.
  - b. In the treatment area.
  - c. At the casualty collection point (if established).

Treatment Areas:

1. There will be two areas designated for treatment: the Immediate Treatment Area and the Delayed Treatment Area. These will be located in an area that is:
  - a. Safe.
  - b. Large enough to handle the number of victims easily.
  - c. Easily accessible to rescue vehicles.
  - d. Away from the morgue.

A third area should be established for those victims with minimal or minor injuries (walking wounded), to account for all the victims.

2. All victims will be sent to the appropriate treatment area.
3. Once they have been triaged, patients will be sent to either the Immediate, Delayed, or Minor Treatment Areas. Continuous triage and patient evaluation should occur in these areas until the patient is transported.
4. Personnel assigned to the treatment area should at all times function only within their scope of practice and under medical control protocol).
5. M.D.'s and R.N.'s should be assigned to the treatment areas.

Transportation:

1. The Medical Transportation Unit Leader, in cooperation with the managers of the treatment areas and the medical communication resource center, will arrange transport of patients to the most appropriate available facility. Patient transportation decisions should be made on the patient's condition, available resources, available facilities, etc.
2. At all times the most Immediate patients should be transported first to the most appropriate available medical facility. Patients may be transported by a lower level of trained personnel as determined by the Medical Transportation Unit Leader in cooperation with the managers of the treatment areas based on available resources and personnel.

3. Patient distribution should occur in such a way that no one facility is overloaded, i.e., the disaster moved from the field to the hospital.
4. Medical transport vehicles should report to the staging area and will be called up by the Medical Transportation Unit Leader as needed.
5. The Medical Communication Manager will contact the medical communication resource center and inform them of patient transportation. The information will be limited to the number of patients, type (Immediate and Delayed), and ETA.
6. The medical communication resource center will relay this information to the receiving facility. BLS transporting units should not contact the receiving facility on the HEAR radio. This frequency shall be used by the Medical Communication Resource Center and receiving hospitals.

ENCLOSURE (3)

CCO 6400.1D  
26 May 99

ICEMA STANDARD PRACTICE RADIO COMMUNICATIONS

EMERGENCY MEDICAL SERVICES AUTHORITY

EMT-IA  
STANDARD PRACTICE

RADIO COMMUNICATIONS

Effective: 02/01/90

PURPOSE:

To define requirements for communication with designated receiving hospitals.

1. Each transporting BLS unit will be equipped with the following:

County approved VHF radio.

2. A receiving hospital must be contacted as soon as possible enroute.

3. ACUTE OR UNSTABLE PATIENT:

The following information will be given to a receiving hospital as soon as possible enroute on any acute or unstable patient:

a. The unit, BLS identification and the situation.

b. The patient description to include age, sex, and approximate weight.

c. Patient's chief complaint and related signs and symptoms, and the mechanism of injury, if appropriate.

d. A report of vital signs to include blood pressure, pulse, respiratory rate and effort. In addition, pupil response, skin vital signs, capillary refill and glasgow coma scale should be reported.

e. Physical examination findings.

f. Care already initiated.

g. E.T.A.

ENCLOSURE (4)

4. ROUTINE TRANSFER OR NOT CRITICAL PATIENT:

An abbreviated report to the receiving hospital will be given on any other patient situation which is a routine transfer or not critical. Minimum patient information: age, sex, chief complaint/injury, limited vital signs (BP, pulse, respiration), ETA. If vital signs are within normal limits, then a statement of "vital signs are within normal limits" will be acceptable.

5. All patient information, treatment, and the time initiated will be recorded accurately and completely on the EMSA Standard Run Form.

6. No patient names will be given over the radio except at the request of the physician and with patient approval, if feasible, when the patient's medical needs exceeds the need for patient confidentiality.



AMBULANCE PATIENT CARE RECORD  
MEDICAL AND LIABILITY RELEASE FORM



FIRE, RESCUE AND EMERGENCY SERVICES BRANCH  
MARINE CORPS AIR GROUND COMBAT CENTER  
TWENTYNINE PALMS, CALIFORNIA 92278-1004



Form supercedes all previous versions (12/98 rsl/pdg)

**MEDICAL AND LIABILITY RELEASE FORM**

I hereby release the \_\_\_\_\_ Mobile Intensive Care and/or Ambulance Service, its employees and administrative officers, the \_\_\_\_\_ Hospital, its Emergency Room Staff, Hospital Employees and Directors and/or Administrative Staff from any liability or medical claims resulting from my refusal of Emergency Care and/or Transportation to the nearest Recommended Medical Facility. I further understand that **I have been directed to contact my Personal Physician as to my present condition.**

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RESPONSIBLE RELATIVE'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS #1 SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS #2 SIGNATURE

\_\_\_\_\_  
DATE

EMERGENCY DEPT. CONTACTED: ☐ YES ☐ NO

**PHYSICIAN'S RESPONSIBILITY**

**DOCTOR, PLEASE READ CAREFULLY; IF YOU DESIRE TO TAKE CHARGE OF THE ACCIDENT/SCENE, YOU MUST;**

1. Show your current California Medical Dr. License to the Ambulance Attendant on the scene.
2. Take full responsibility for the care & treatment of the patient(s) involved in the incident.
3. Accompany the paramedics/EMTs and ambulance with the patient(s) to the medical facility most appropriate to receive the patient(s).

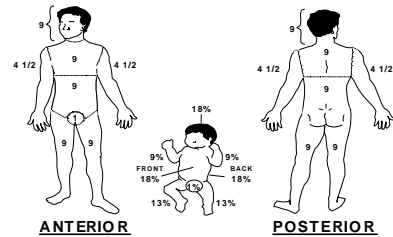
\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PROFESSIONAL LICENSE #

\_\_\_\_\_  
DATE

ADDITIONAL COMMENTS: \_\_\_\_\_

**BURN CHARTING / DEGREE OF SEVERITY**



Burn Comments: \_\_\_\_\_

Form supercedes all previous versions (12/98 rsl/pdg)

ENCLOSURE (5)

CCO 6400.1D  
26 May 99

MUTUAL AID

1. All off-base medical responses shall be per the following existing Mutual Aid Agreements:

- a. County Service Area (CSA) 38
- b. FMF Augment EAF
- c. Twentynine Palms Fire Department
- d. Yucca Valley Fire Protection District
- e. Wonder Valley Fire Protection District
- f. San Bernardino Office of Environmental Health

2. An on-going program of education and training involving the Naval Hospital, Fire Department, and other agencies involved shall be established and maintained to ensure proper training and coordination of emergency medical services and other mission requirements.